Walgreens
Healthcare Plus

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REGISTRATION & PRESCRIPTION ORDER FORM

Please **PRINT** clearly using **UPPERCASE** letters. Use black ink only. Enclose this form with your mail service prescription.

CITY OF TEMPE

GROUP NO.: **512220** INTERCOM: **WHP** UPI: **WHP267**

MEMBER ID NUMBER (VERY IMPORTANT)

Please complete both pages of this form.

#1 MEMBER INFORMATION

Name (First, Last)

E-mail address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list): ☐ No Known ☐ 87-Sulfa ☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS:
☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease
☐ 500-Glaucoma ☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps.
☐ Check if patient needs Spanish vial labels.

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Healthcare Plus will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Service number to advise.

PAYMENT (required at time of order):

Rx Type	No.	Cost (ea.)	Subtotal
Generic		**$***	$
Brand		**$***	$
TOTAL AMOUNT ENCLOSED			$

Signature (for credit card):

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; **no cash, please**) CREDIT CARD EXPIRATION /

Checks payable to: **Walgreens Healthcare Plus** P.O. Box 29061, Phoenix, AZ 85038-9061

CUSTOMER SERVICE: 1-800-345-1985 (☎ TTY for deaf: 1-800-573-1833)

REFILLS BY PHONE: 1-800-RX-REFILL (1-800-797-3345) (en español: 1-800-778-5427)

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

Thank you for your order. Please allow two weeks for delivery from the date you mail your order.

I/07-04

1 5 4 0 0 0 0 0 W H P W H P 2 6 7

#2 Dependent Information

Name (First, Last)

E-mail address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

#3 Dependent Information

Name (First, Last)

E-mail address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

#4 Dependent Information

Name (First, Last)

E-mail address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

☐ Check if patient needs snap-on caps
☐ Check if patient needs Spanish vial labels

#5 Dependent Information

Name (First, Last)

E-mail address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

Dr. Name (print) | Dr. Phone (very important) ( )

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